OVHA Pharmacy Bulletin

In support of our Pharmacy Partners

Volume 10 **March 2009**

NEWS AND UPDATES

OVHA Welcomes New Pharmacy Director

We are pleased to announce that Cynthia D. LaWare has joined the Office of Vermont Health Access as its new director of Pharmacy Benefit Programs. Ms. LaWare brings a wealth of experience in state government both in human resources and as the former head of the Agency of Human Services. She also has extensive business experience in the private sector. Cindy can be reached at (802) 879-5900.

OVHA Pharmacy Best Practices and Cost Control Report for 2009

The OVHA Pharmacy Best Practices and Cost Control Report for 2009 is now available for public viewing at: http://ovha.vermont.gov/for-providers/pharmacy-reports.

This annual review of OVHA's pharmacy programs includes descriptions of:

- pharmacy benefit design
- program features designed to ensure access to quality products while managing expenditures
- pharmacy expenditures and utilization patterns
- reimbursement comparison to other states
- activities of the Drug Utilization Review (DUR) Board
- future plans affecting pharmacy benefits

Specialty Pharmacy Services

As of 2008, the PBM program requires that selected pharmaceutical products used to treat complex medical conditions be obtained from specific pharmacies. Our goal is to assure that, when beneficiaries receive drug therapies for complex medical conditions, those treatments provide the patient with the opportunity to obtain the best health outcomes through the availability of disease and case management services in the most economical manner possible.

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Specialty Pharmacy Services (continued)

After a competitive bid process, two specialty pharmacies were chosen to provide these products and services:

- Wilcox Medical began providing specialty pharmacy services for Synagis®, the drug used to prevent respiratory syncytial virus (RSV), in October, 2008.
- ICORE Healthcare, LLC, with MedMetrics Health Partners, began providing these services for other select specialty drugs:
    - As of November 3, 2008: hemophilia factors, growth hormones, multiple sclerosis self-injectables, hepatitis C (ribavirin and injectables) treatments, and Elaprase® (for Hunter's Syndrome).
    - As of February 16, 2009: Drugs to treat rheumatoid arthritis, psoriasis, psoriatic arthritis, juvenile arthritis, Crohn's Disease and ankylosing spondylitis. Agents include Humira® (adalimumab), Enbrel® (etanercept), Raptiva® (efalizumab), and Kineret® (anakinra).

Dispensing of these medications is limited to these pharmacies for Medicaid beneficiaries where Medicaid is the primary insurer. This does not affect members whose Medicaid coverage is secondary to another insurer, including Part D members.

OVHA Website Resources

We often receive questions from pharmacy staff that could be answered by quickly checking the OVHA's pharmacy unit webpage at http://ovha.vermont.gov/for-providers. Information found on our site includes:

- Bulletins & Advisories
- Consumer Issues
- Coverage & Billing Issues (Medmetrics Health Partners)
- Customer Newsletters
- Drug Utilization Review Board
- FDA Alerts
- Forms
- MAC List
- NPI Deadline for Prescribers
- Part C & D Resources
- Pharmacy Benefits Management
- Preferred Drug List & Clinical Criteria Manual
- Prior Authorization Request and Order Forms
- Prior Authorization Review Process
- Program Coverage
- Provider Manual
- Reports
- Requests For Proposals (RFPs)
- Sovereign States Drug Consortium
- Specialty Pharmacy Services
- Tamper-Resistant Drug Pads
- VScript Labelers

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HELP US HELP YOU!

Most Common Billing Errors / Provider Manual Update

As we look back on 2008, we thought it would be helpful to remind you of the most common incorrect billing practices we typically see. They are:

- Submitting incorrect Prescriber NPI.
- Submitting incorrect Other Coverage Codes (NCPDP Field 308-C8). An example includes:
  - Using an OCC of 4 (indicating deductible or donut hole) when the primary payer either was not billed or denied the claim.
- Omitting an amount in the "Other Payment Amount Paid" field (NCPDP Field #431-DV).
- Submitting the wrong amount in the "Other Payer Amount Paid" field. An example includes:
  - Placing $0.01 in the field to force the Medicaid system to pay the claim when either the primary payer was not billed or denied the claim.
- Billing Medicaid as primary when other insurance exists.
- Billing Medicaid for more than one dispensing fee per 30-day period for maintenance medications.

We hope this reminder is helpful and we encourage you to review your current billing practices to ensure they are in compliance with the Provider Manual, which has been updated recently and sent to all participating pharmacies.

As well, the most up-to-date version will always be available online at: http://ovha.vermont.gov/for-providers. Should you have specific questions or need assistance, please feel free to contact Jennifer Mullikin at (802) 879-5648.

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Other Coverage Codes (OCC) – A Reminder

Although we have provided this information in the past, it's always helpful to be periodically reminded of the correct use of OCC codes when billing for members enrolled in Vermont's publicly funded pharmacy programs. Hope it helps!

OCCURRENCE	CORRECT OTHER COVERAGE CODE TO USE	(OVHA – VTM) Processing Policy Vermont Coverage Secondary to Alternate Insurance	(OVHAD – VTD) Processing Policy Vermont Coverage Secondary to Medicare Part B and Part D
The primary insurance plan pays a portion of the claim.	2 = Other coverage exists, payment collected from primary insurance.	Requires Submitted Patient Pay field and COB segment, detailing information on paid claim, including Other Payer ID and Other Payer Paid Amount. Claim will process based on Medicaid allowed amount. Leaving this field blank is not permitted as it will result in the State paying the entire claim in full. These claims will be subject to recoupment.	Requires Submitted Patient Pay field and COB segment, detailing information on paid claim, including Other Payer ID and Other Payer Paid Amount – claim will pay based on member cost share from PDP. Limitations: 1) OCC2 does not apply to full-benefit duals except in the event that the PDP makes a payment for a CMS Part D excluded drug (e.g. benzodiazepine). 2) Payment limited to $6.00 for VPharm 100% LIS members. Leaving this field blank is not permitted as it will result in the State paying the entire claim in full. These claims will be subject to recoupment.
The primary insurance rejects the claim.	3 = Other coverage exists, claim rejected by primary insurance.	**Only to be used for over-the-counter drugs.** Claims submitted with an OCC = 3 will be subject to an edit to determine if drug is OTC; if so, the state will pay claim if all other state criteria is met. State would prefer Other Payer Reject Code, but field is not currently required. **For non-OTC drugs:** If the primary payer denies a claim because the drug requires a prior authorization or it is a non-formulary drug, then the primary carrier's prior authorization procedures must be followed.	Claims submitted with an OCC = 3 will be subject to an edit to determine if drug class is Excluded from Part D coverage by CMS; if so, state will pay claim if all other state criteria is met. If product is not an Excluded Drug from CMS for Part D coverage, state will reject claim. State would prefer Other Payer Reject Code, but field is not currently required. OCC=3 does not apply to Medicare Part B.

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OCCURRENCE	CORRECT OTHER COVERAGE CODE TO USE	(OVHA – VTM) Processing Policy Vermont Coverage Secondary to Alternate Insurance	(OVHAD – VTD) Processing Policy Vermont Coverage Secondary to Medicare Part B and Part D
The primary insurance carrier processes the claim but does not make a payment because: **a) The member is in a deductible period,** **b) The member is in the Part D donut hole, or** **c) The payment is less than the patient's copayment**	4 = Other coverage exists, payment not collected from primary	Requires Submitted Patient Pay field and complete COB segment. Claim will pay based on Medicaid allowed amount. OCC = 4 is not to be used when the primary claim has been denied by the primary insurance plan because the drug requires a prior authorization or it is a non-formulary drug. If found during a State audit, these claims will be subject to recoupment.	To be used when member has deductible or "donut hole" and primary payer is not making payment on claim; requires Submitted Patient Pay field and complete COB segment. Claim will pay based on member cost share from PDP. Also used for Part B deductible. Limitations for OCC4: 1) Does not apply to Part D claims for full-benefit duals, and 2) Payment limited to $6.00 for VPharm 100% LIS members. OCC = 4 is not to be used when the primary claim has been denied by the Part D Plan because the drug requires a prior authorization or it is a non-formulary drug. If found during a State audit, these claims will be subject to recoupment.
The primary insurance plan rejects the claim because coverage no longer exists.	7 = Other coverage exists, not in effect on Date of Service (DOS)	To be used if member's other coverage no longer exists; state will process claim.	Claim will reject.
The Part D Plan processes the claim with a negative amount for payment.	8 = Billing for Copay	Not applicable	(*Only used when Other Payer Paid Amount is $<0*) Requires Submitted Patient Pay field and COB segment, detailing information on paid claim, including Other Payer ID and *negative* Other Payer Paid Amount. Claim will pay based on member cost sharing.

To submit questions or suggest topics send an email to: ***OVHA-PH@ahs.state.vt.us***